Certificate Number:

Premium Payment Mode ☒ M ☐ Q ☐ A

☒ Health Choice Benefit Plan (25875)
Ded ☐ $1000 ☒ $2000 ☐ $3000 ☐ ____
R & B ☐ $200 ☒ $300 ☐ $400 ☐ $500 ☐ $600 ☐ ____

☐ Signature Benefit Plan (25876)
Ded: ☐ $1500 Coins: ☐ 50% ☐ 80%
Ded: ☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000
Coins. ☐ 50% ☐ 80% ☐ 100%

☒ Critical Care (GSD) Amt. $____

☐ Premiere PPO (25877)
Ded. ☐ $1,000 ☐ $1,500 ☐ $2,500 ☐ $5,000 ☐ $7,500

☐ Premiere PPO Plus (25877)
Ded. ☐ $1,000 ☐ $1,500 ☐ $2,500 ☐ $5,000

☐ HIPAA ☐ Individual Plan ____ Ded. $____
☐ Group R&B____

Lead # 122792203 ☐ Referral 20860531000

ADDITIONAL BENEFITS

☒ Rx Plan A ☒ Vision (25213) #____ ☐ Dental (25879)#____
☐ Acc. Med. (25315) R&B $____ Ded. $____
☐ Acc. Cat. (25314) Coins ____% Ded. $____
☐ Inc. Prot (25916) ☐ Inc. Prot Plus (25915) ☐ B ☐ W
Indem. Ben. $____ Elim. Per. ____days
☐ Waiv. Prem (25917) ☐ ROP (25918)
☐ Life Plan (25430) ☐ Life Plus Plan (25919)
Prim. ☐ ADB ☐ ALB Prim. DI Indem Ben $____
Sec. ☐ ADB ☐ ALB Sec. DI Indem Ben $____
☐ Primary $____ ☐ Smoker ☐ Non-Smoker
Beneficiary____ SS#____
☐ Secondary $____ ☐ Smoker ☐ Non-Smoker
Beneficiary____ SS#____

RIDER/OPTIONAL BENEFITS

☐ Out Acc (25882) Ded. $____ Max. $____
☐ Cont Care (25883)
☐ Preg./Birth (25884) $____
☒ Amb Care (25885)
Ded. $ 100 Max. $ 1000 Coins. $0 %
☒ POV (25886) ☒ 1/16 ☐ 2/24
☒ Chemotherapy (25887)
☒ Wellness (25888)
☒ ACE (25890)
☐ ROP (25044)
☒ Air Amb (25902)
☒ R&B Enh $ 200
☐ Misc ☒ 2x ☐ 3x
☐ Surgical ☒ 2x ☐ 3x
☐ Other ____

Special Requests

Association Membership
I am a member of the following Association: NASE
Member Level: PLATINUM PLUS Member# NEW
☐ Assoc. Advantage Card ____ Dental____

Enrollment Application for: The MEGA Life and Health Insurance Company • Oklahoma City, OK 73118

1. SCHEDULE OF FAMILY MEMBERS - FIGURE HEALTH PREMIUM AT AGE LAST BIRTHDAY

PLEASE PRINT (FULL NAME)	SEX	RELATIONSHIP	DOB	BIRTHPLACE	AGE	HEIGHT	WEIGHT	SOCIAL SECURITY #
(1) WILLIAM VERNON Meadows	M	PRIMARY	11/30/49	PELHAM GA	52	6'00"	185	252-86-2845
(2) JEANIE LEAVERN Meadows	F	WIFE	3/15/55	GRADY, GA	46	5'04"	140	254 94 0474
(3)								
(4)								
(5)								
(6)								

Marital Status: ☐ Single ☒ Married

Applicant's Home Address:
Address 1113 OAK AVENUE
City ELBA ST AL Zip 36323
County COFFEE
Daytime Telephone (334) 897 - 8202
Home Telephone ( ) -
E-mail Address CMEADOWS@ALAWEB.COM
Fax Number ( ) -
Are all members U.S. Citizens? YES
If "No," please explain: ____
How long in the U.S.? ____

Occupation and duties of adult family members:
(1) MAINTENANCE AND REPAIR
(2) ____

Are all members between the ages of 19 and 24 full-time students? ____
If "Yes," name school ____
If "No," which applicant? ____
Explain ____

Is the Applicant, spouse or any dependent child (even if not proposed for insurance) now pregnant or an expectant father?
If "Yes," whom? NO
Estimated date of delivery ____

Is any Applicant eligible for or covered under Medicare or Medicaid? If "Yes," whom? NO

Do you currently have health/life insurance? NO
If "Yes," is it ___ Group or ___ Individual, names of companies, certificate/policy number, amounts and types of coverage?
____

Date of cancellation ____
Will existing health/life coverage be replaced or changed if proposed health/life coverage is issued? ___ Yes ___ No
If no, reason ____

10. Does any Applicant to be insured engage in any hazardous sport or activity? (e.g.: flying, diving, skydiving, racing.)
Name: NO Activity: ____

11. During the past ten years, has any person to be insured had insurance declined, rated, ridered, or otherwise changed? NO
If "Yes," which applicant ____ Date ____
Reason ____
Company ____

12. a) Applicant's Doctor DR. RUSSELL COOK
Address 207 E WATTS ST. #220
City ENTERPRISE State AL Zip 36330
Telephone Number (334) 393 - 1057
b) Spouse's Doctor DR. FERNANDEZ, JOSEAH
Address 207 WATTS STREET WEST
City ENTERPRISE State AL Zip 36330
Telephone Number (334) 393 - 8252
c) Child(ren)'s Doctor ____
Address ____
City ____ State ____ Zip ____
Telephone Number ( ) -

13. Is any member presently taking any medications? YES
a) Who? JEANIE WILLIAM
b) What? ESTRACE ELMIRON ZESTRIL LIPITOR
c) Why? ESTROGEN BLADDER HIGH BLOOD PRESSURE, CHOLESTEROL

14. Has any applicant used tobacco products in the last 12 months? YES If "Yes," who and what? WILLIAM, SMOKE

ME000064

98-APP (9/99)

EXHIBIT B

15. Have you or any Applicant ever had your driver's license suspended, revoked or ever received any citations for driving while under the influence (i.e. DWI or DUI)? YES (WILLIAM)
If "Yes," list details. DUI - 1995

16. a. When was the last time the applicant visited a doctor? 2001
Symptoms? BLOOD PRESSURE Results? OK (NORMAL) Recommendations? STAY ON MEDICATION
b. When was the last time the spouse visited a doctor? 2001
Symptoms? OB/GYN VISIT Results? OK Recommendations? NONE
c. When was the last time the child(ren) visited a doctor?
Symptoms? Results? Recommendations?

17. Have you or any person to be insured EVER had symptoms, been diagnosed, received medical advice or been treated for (If "Yes," circle applicable condition):

	YES	NO
a) Heart disorder, including murmur, heart attack, chest pain, artery or vein disorder, high blood pressure or stroke?	X	
b) Diabetes, hypoglycemia, goiter or thyroid disorder?		X
c) Blood or spleen disorder including anemia or leukemia?		X
d) Breast or reproductive organ disorder?		X
e) Cancer, cyst, tumor or neoplasm?		X
f) Respiratory disorder, including asthma, bronchitis, COPD, emphysema, lung disease or breathing problems?		X
g) Kidney, urinary bladder, urinary tract, stones or prostate disorders?	X	
h) Stomach, intestines, gallbladder, liver or pancreas disorder including ulcer, colitis, enteritis, hepatitis or pancreatitis?		X
i) Hernia, hemorrhoids, polyps or rectal disorder?		X
j) Eye, ear, nose or throat disorders?		X
k) Skin disorders, burns, lacerations, dermatitis, boils or chronic rashes?		X
l) Back, spine, arm or leg disorder or arthritis, gout - bursitis or neuritis?		X
m) Complications of pregnancy and/or Caesarean section?		X
n) Brain disorder, epilepsy, fainting spells, dizziness, seizures, paralysis, tremors, palsy, head injury or chronic headaches?		X
o) Mental or nervous disorder, depression, anxiety, alcoholism or drug addiction?		X
p) Been diagnosed by a physician for any disorder of the blood or immune system including AIDS?		X
Any other medical or surgical advice, hospitalizations, treatment or operations in the last five (5) years?		X

18. Any other medical or surgical advice, hospitalizations, treatment or operations in the last five (5) years.

19. IMPORTANT: Give complete details of any "Yes" answers to questions 17 through 18.

Name	Nature of Illness or Accident (Include Diagnosis, Operations, and Medications)	Date Started	Date Stopped	Operation	Hospitalized From/To	Doctor's Name and Address
WILLIAM	HIGH BLOOD PRESSURE-meds control	1990	CURRENT	☐ Yes ☒ No	N/A	DR. GWINN - DOTHAN
WILLIAM	BLADDER PROBLEM-meds control	1995	CURRENT	☐ Yes ☒ No	N/A	DR. FERNANDEZ - ENTERPRISE
JEANIE	BLADDER PROBLEM-meds control	1999	CURRENT	☐ Yes ☒ No	N/A	DR. GWINN - DOTHAN
WILLIAM	CHOLESTEROL (HIGH) Meds control	1999		☐ Yes ☐ No		DR. VERNON GWINN - 1150 ROSS CLARK CIR DOTHAN, AL 36301 (334) 712-1929
				☐ Yes ☐ No		

Should space provided be inadequate, use separate paper to record complete information with signature of applicant.

meds control bladder problems

DECLARATIONS AND AGREEMENTS

I agree that (a) all statements and answers in this Application are true to the best of my knowledge and belief; (b) this Application will form a part of the contract; (c) the agent does not have the authority on behalf of the Company to accept the risks, or to make, alter or amend the coverage or to extend the time for making any payment due on such coverage and (d) no insurance will take effect unless and until the Application is approved by the Company and the policy/certificate is delivered to the Applicant while the conditions affecting the insurability are and have remained as described herein and the first premium has been paid in full.

INSURANCE FRAUD WARNING

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading is guilty of insurance fraud and is subject to criminal and/or civil penalties.

I have received and understand the Notification of Consumer Report and Medical Information Bureau Pre-Notice.

Signed 03 / 12 / 02 (Date) at ELBA (City), AL (State)

x [signature] Signature of Applicant

x [signature] Signature of Spouse (If to be covered)

To Be Answered By Agent:
I certify that each question on this application was asked by me of the Applicant(s) named above, and all answers are accurately recorded.

x [signature] Signature of Licensed Agent

MICHAEL JOSHUA MILFORD Print Full Name

79EM Agent No.

25098-APP (9/99)

ME000065

(12/

The MEGA Life and Health Insurance Company

Please Read This Before Signing!

208605310003

To The Applicant:

The best business relationships are those in which there is complete and clear understanding between the parties. Accordingly, we ask that you read and sign the following statement after the representative has made a complete presentation of the plan to assure yourself that you completely understand the coverage.

CONFIRMATION OF PRESENTATION AND ACKNOWLEDGMENT OF DELIVERY AND MIB AUTHORIZATION

Attention: Underwriting Department

Upon my request, your representative, whose signature appears below, visited me to determine my interest in applying for insurance with your company. Your representative was courteous and fully and completely explained to me from the same certificate, all the provisions as contained in the certificate, including every benefit, exclusion, limitation, waiting period, and deductible, if any. Your representative asked each question on the enrollment application, which I signed only after a full review of the provisions and all the answers had been filled in. The answers to the health questions were fully answered to the best of my knowledge, and all the answers on the application are exactly those, with nothing left out, which I in any way related or stated to the representative. I fully understand and agree that if any material information is omitted from the application, it could provide the basis for the Company to refuse coverage and to refund all my premium as though my coverage had never been in force. In signing this form, I agree that I have carefully examined and understand the provisions of the specimen certificate and application, and that the Company is not bound by any knowledge of or statement made by or to the representative, unless set forth here on the application.

I understand that several deductible options are available under the plan described to me. I further understand that the larger deductible I select, the greater my out-of-pocket expenses will be as the deductible must always be satisfied by me before the Company will pay benefits.

The Direct Benefit Plan (Form #25874-C or its state variation) is a LIMITED BENEFIT insurance plan. It does not contain medical expense benefits. Your representative has not referred to, or represented the Direct Benefit Plan as health insurance or major medical insurance. The Direct Benefit Plan provides fixed benefits payable when Hospital Confined. You may use your benefits any way you want, including bills you may have received while Hospital confined.

I hereby authorize any licensed physician, medical practitioner, pharmacy, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any record or knowledge of me or my family, to give The MEGA Life and Health Insurance Company, or its reinsurer, any such information. The MEGA Life and Health Insurance Company may also release information about me to its reinsurer. I authorize The MEGA Life and Health Insurance Company to obtain an investigative consumer report on me. A photographic copy of this authorization shall be as valid as the original.

I understand that coverage is not effective unless and until approved and issued by the Company.

Applicant WILLIAM MEADOWS Date 03/12/02 Representative MICHAEL MILFORD # 995M

Return this form with the application.

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORD INFORMATION

By my (our) signature(s) below, I authorize *any health care provider*, including physicians, pharmacies, clinics, hospitals or other institutions who are named in the application for insurance or who attends or has attended myself, my spouse, or any of my children, at any time, to disclose to The MEGA Life and Health Insurance Company or its legal representative, *information from my or my family's health care record.* I understand this could include, but is not limited to, my identity, medical history, diagnosis, prognosis, dates of treatment, treatment, test results, and summary reports, and this disclosure is without limitation to period of treatment, diagnostic or therapeutic information, history or type of illness including treatment, if any, for alcohol and drug abuse.

I UNDERSTAND the information obtained by use of the Authorization will be used by The MEGA Life and Health Insurance Company to determine eligibility for insurance, and eligibility for benefits under an existing policy. Any information obtained will not be released by The MEGA Life and Health Insurance Company to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required as I may further authorize.

I KNOW that I may request to receive a copy of this Authorization.
I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE this Authorization shall be valid for two years from the date shown below.
I ACKNOWLEDGE receipt of the Description of Information Practices.

I ELECT to be interviewed if an investigative consumer report is prepared in connection with this application. ☒ Yes ☐ No

Signed this 12 day of MARCH 20 02

Name of Minor Child

Signature of Proposed Insured

Name of Minor Child

Signature of Spouse

Name of Minor Child

Witness (Agent)

M/2000 APP (12/01)

ME000066

Disclosure Statement

The LIFE Plan Insurance program is a Ten-Year Term Life Insurance Policy that is renewable to age 65. "Living Benefits" are provided by Optional Accelerated Living Benefit, and Terminal Illness Benefit Riders. Accidental Death Benefits are provided by an Optional Accidental Death Benefit Rider.

DISCLOSURE STATEMENT - ACCELERATED BENEFITS

(Complete if Accelerated Living Benefit Rider and/or Terminal Illness Rider are Selected with Life Plan)

☐ **Accelerated Living Benefit Rider:** If the Insured is diagnosed with a Heart Attack, Stroke, Coronary Artery Bypass Surgery, or Life-threatening Cancer, this rider pays 25% of the Face Amount.

☐ **Terminal Illness Rider (Accelerated Benefits):** If the Insured is diagnosed with a terminal illness that is expected to result in death in 12 months, this rider pays 50% of the Face Amount, less any benefits already paid.

Receipt of accelerated benefits may be taxable. Please consult your tax advisor regarding your tax status.

I acknowledge receipt of this Disclosure Statement regarding Accelerated Benefits. I also acknowledge receipt of a Numerical Illustration regarding the effect of the accelerated benefit on other policy/certificate values/amounts.

Signature of Proposed Insured/Applicant _____ Date _____

Signature of Agent _____ Date _____

Please complete and return if purchasing Accelerated Living Benefit Rider with the Life Plan

SUPPLEMENT TO ENROLLMENT APPLICATION

Have you or any other person applying for coverage ever had a parent, brother, or sister who had been diagnosed or treated for cancer, stroke, diabetes, heart disease or kidney disease? (if yes, complete the chart below)

YES ☐ NO ☐ (if yes, complete the chart below)

FAMILY RECORD OF PROPOSED INSURED

	Person #	Impairment	Age of Onset	Age of Death
Father				
Mother				
Brothers				
Sisters				

Signature of Proposed Insured (Primary) _____ Date _____

Signature of Proposed Insured (Spouse) _____ Date _____

Signature of Agent _____ Date _____